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Effect of Trauma Due to War on Dissociative Symptoms and Resilience among Palestinian Adolescents in the Gaza Strip

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تأثير الصدمة جراء الحروب على حدوث الأعراض التفككية والصمود لدى المراهقين الفلسطينيين في قطاع غزة

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Abstract

Aim: The present study examined the effect of war trauma on occurrence of dissociative symptoms and the role of resilience among Palestinian adolescents in the Gaza Strip. **Method:** N=400 adolescents (179 boys, 221 girls) were randomly selected from 10 schools in five areas in the Gaza Strip. The Gaza Traumatic Checklist, Dissociative Symptoms Scale for Adolescents, and Resilience Scale for Adolescents were used for assessment and socio-demographic data collected. **Result:** Regardless of gender, all participants reported an average of nine traumatic events regardless of family income, number of siblings, parent education and work status. The mean score for dissociative symptoms in girls was 75.67 vs. 73.65 in boys. No statistically significant differences in dissociative symptoms according to gender, age, place of residence, parent education and work status. Mean resilience was 112.18, individual resources, e.g. personal skills, social skills, and peer support was 44.06; physical and psychological caregiving by primary caregivers was 27.42, and contextual resources including spiritual, cultural and educational resources mean was 37.42. No statistically significant differences in the total resilience and subscales according to socio-demographic factors of gender, age, type of residence and parents work, whereas, resilience was higher in those with fewer siblings. There was a statistically significant negative relationship between dissociative symptoms and total resilience, individual resources, physical and psychological caregiving, and contextual resources. There was a statistically significant positive relationship between traumatic events and total trauma and total resilience, individual resources, and contextual resources. **Clinical implications:** Palestinian adolescents have been victims of continuous trauma with increased risk of psychopathology such as dissociative symptoms. Such symptoms negatively impacted upon adolescent resilience when handling adversity. Findings suggest the need for psychosocial interventions that reflect public health and child developmental requirements. Engaging children in interventions that are community-based recreational and cultural activities in war-affected populations have been found useful to heal.

Key words: Trauma, war, adolescents, dissociation, resilience, Gaza Strip

Declaration of interest: None

Introduction

Most people are exposed to at least one violent or life-threatening situation during the course of their lives. As they progress through the life cycle, they are increasingly confronted with the deaths of close friends and relatives. Everyone copes differently with these potentially disturbing. Some will experience acute distress from which they are unable to recover; others suffer less intensely and for a much shorter period of time; some people seem to recover quickly, but then begin to experience unexpected health problems or difficulties concentrating or enjoying life the way they used to[1]. Children of Gaza have been subject to a wide range of traumatic and violent events over the last few decades, which, when considered alongside other risk factors such as gender, socio-economic status and previous mental

health history, have led to significant psychosocial problems[2, 3, 4].

Dissociation is defined as the individual's lack of ability to integrate a potentially traumatizing event, implying that he or she avoids painful memories[5]. Dissociation can be divided into psychoform and somatoform types. Psychoform dissociation involves disruptions in the integration and perception of cognition, affect, memory, identity, and behavior. Somatoform dissociation involves disruptions in the integration and perception of bodily functions, sensations, and movement. Trauma has been linked to both forms of dissociation[6,7]. Dissociation is a complex psycho physiological process that alters the accessibility of memory and knowledge, integration of behavior, and sense of self[8]. Dissociation reflects the disruptions in the normal flow of information processing and in functions that are usually integrated: consciousness, memory, identity or perception of the environment[9]. Many studies tried to assess the dissociation as response to traumatic events, one of these studies demonstrated that dissociative symptoms were widespread among homeless young as a way to handle their situations[10]. Childhood trauma has been associated with increased risk for both panic disorder and dissociative symptoms in adulthood[11]. Another study on the relationship between different types of childhood trauma and the degree of dissociative experiences among adolescent psychiatric patients showed an increase in the degree of dissociative symptoms in patients with a history of sexual abuse, physical abuse, neglect and stressful life events[12]. Others showed that symptoms of posttraumatic stress and impaired capacity to regulate negative emotional states significantly increased the likelihood that dissociative symptoms would develop. The study found that the variables seemed to interact independently of each other, in such a way that there was no statistical interaction between the two. Instead the two variables seemed to be independent, both acting as additive moderators of trauma related dissociation[13]. Recent research on adolescents has also pointed to the cumulative effect of traumas and adverse life experiences on the occurrence and intensity of posttraumatic and dissociative symptoms[14, 15].

Resilience is broadly understood to mean "positive adaptation in the face of adversity" [16]. This definition highlights the two criteria that are crucial to a description of a young person as resilient. First, a context of adversity, including psychosocial threat, experiences of trauma, and/or biological risk, must be identifiable; and second, a young person must adjust well to this context of risk. While others defined resilience as 'both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways'. From this, it is clear that an outcome of resilience is contingent on a process that involves reciprocal transactions between children, who 'navigate' and/or 'negotiate,' and their ecologies, which 'provide'[17].

Researchers and practitioners working within a resilience framework recognize that many adolescents growing up in poverty exhibit positive outcomes; they may possess any number of promoted factors, such as high levels of self-esteem or the presences of an adult mentor all of which helps them avoid the negative outcomes associated with poverty. Researchers have also described resilience as an outcome when they identify as resilient an adolescent who has successfully overcome exposure to a risk[18]. Many studies tried to connect trauma and resilience; by this resilience will be a form of behavioral adaptation to situational stress and a style of personality functioning. Resilience and mental health are interlinked, overlapping, and bi-directional such that a young person with a mental health problem can be resilient or a resilient child or youth can develop a mental health problem[19].

The present study aimed to examine the effect of trauma on dissociative symptoms and resilience among Palestinian adolescents in the Gaza Strip.

Method

The Gaza Strip is a narrow elongated piece of land, bordering the Mediterranean Sea between Israel and Egypt, which covers 360 km2. It has a high population density. About 17% of the population lives in the north of the Gaza Strip, 51% in the middle, and 32% in the south area. There is high unemployment, socioeconomic deprivation, family overcrowding, and short life expectancy. Nearly two-thirds of the population are refugees with approximately 55% living in eight crowded refugee camps. The remainder live in villages and towns[20].

Sample

The target population consisted of 430 children, between 15 to 18 years old, who were exposed to the war on the Gaza Strip on November 2012, and who lived in five localities of the Gaza Strip (North, Gaza, Middle, Khan Younis, and Rafah). The sample was selected randomly according to a prepared list of boys and girls from each of the 10 schools from the five areas. Of the total 430 who were contacted, 400 agreed to participate in the present study, following informed consent from their parents, with a response rate of 93%. Two hundred and twenty one (55.2 %) were girls and 179 (44.8%) were boys (Figure 1).

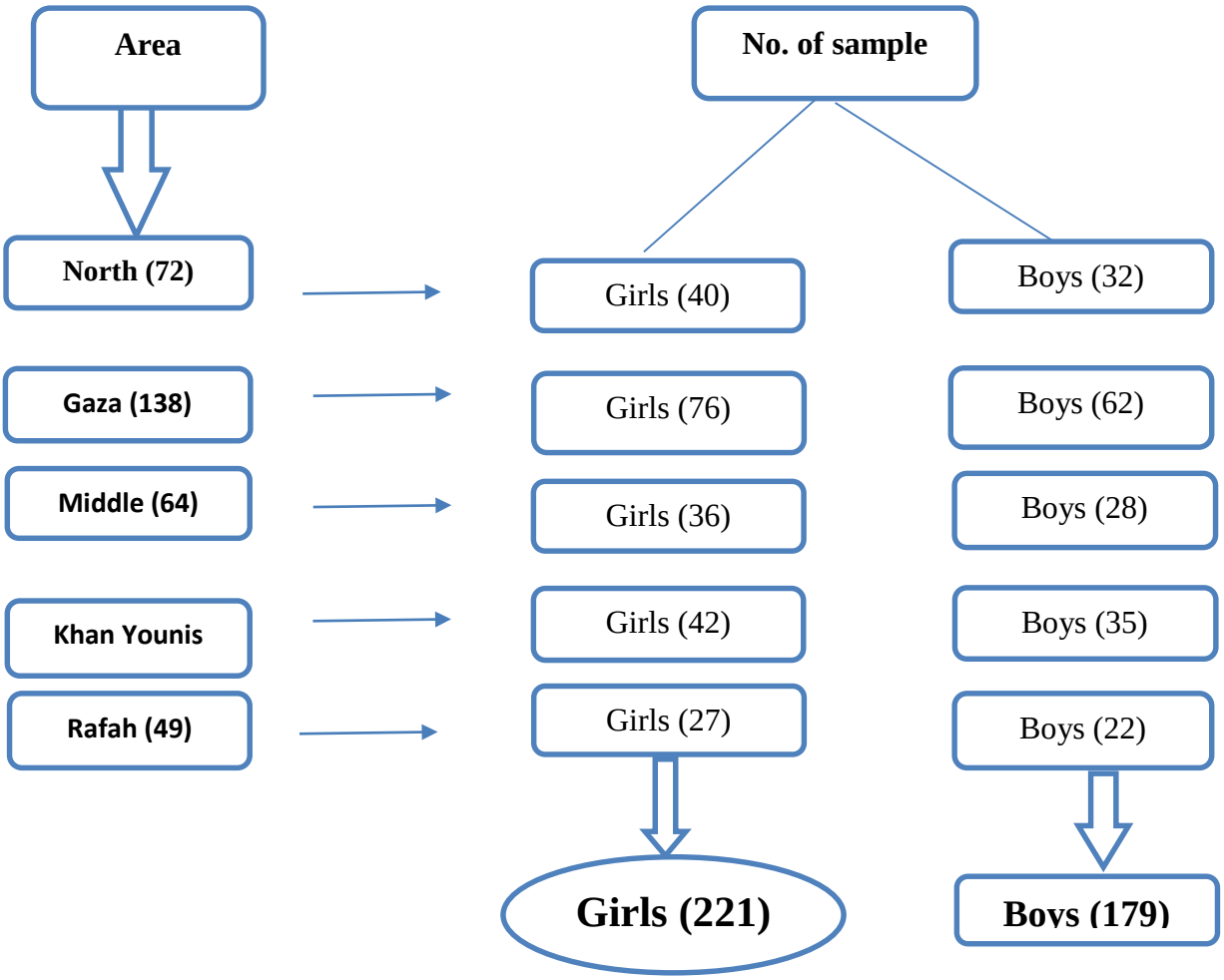

Figure 1: distribution of the sample according to gender and area

Procedure

Data collection was carried out by four trained psychologists and social workers, under the supervision of the first author. They were trained for six hours in data collection and interviewing techniques. The data was collected during March 2013. The completion of the self-administrative measures took at least one hour for each child. Sociodemographic information, exposure to traumatic events, dissociative symptoms, and resilience were completed by the adolescents.

Measures

The data was collected using the following:

Demographic questionnaire

A demographic questionnaire, developed for the present study, was completed by all participants. The questionnaire asked participants to answer questions regarding their gender, age, type of residence, number of sibling, parent's education, family income and parents' work.

Gaza Traumatic Events Checklist for 8 days war on Gaza[21]

The Gaza Traumatic Checklist was originally developed by the Gaza Community Mental Health Program to assess level of trauma exposure typical for the Palestinian population in Gaza. This version of the Gaza Traumatic Event Checklist was updated after the most recent war on Gaza in 2012. The checklist consisting of 18 items covering three domains of events typical for the war on Gaza: (1) Witnessing acts of violence, e.g., killing of relatives, home demolition, bombardment, and injuries; (2) Having experiences of loss, injury and destruction in family and other close persons; and (3) Being the target of violence, e.g., being shot, injured, or beaten by the soldiers. Respondents were asked whether they had been exposed to each of these events: (0) no (1) yes. The internal consistency of the scale was calculated using Chronbach's alpha ($\alpha = .64$).

Adolescents Dissociative Experiences Scale (A-DES) [6]

The A-DES is a 30-item self-report questionnaire that measures the presence and frequency of normal and pathological dissociative experiences in adolescents (12–18 years old). For each item, participants are asked to indicate how often each experience happens to them on an 11-point Likert scale ranging from 0 (never) to 10 (always). The A-DES is scored by dividing the participant's total score by 30 to give a mean score ranging from 0 to 10. Higher mean scores on the A-DES are indicative of higher levels of psychoform dissociation. The scale was translated to Arabic and back translated and reviewed by the relevant experts for validity of the items and feedback was considered with minor changes. For the present study the adolescents indicated how much each experience happens to them on a 1 to 5 scale ("never" to "always"). Internal consistency was validity using Chronbach's alpha ($\alpha = 0.91$).

Resilience Scale for Adolescents[22, 23, 24]

The scale is a 28-item self-report scale using a 5-point Likert scale, with all items positively phrased. Items are rated on a five-point scale from 1=does not describe me at all to 5=describes me a lot. The three subscales are: Individual resources (11) such as personal skills, social skills, and peer support; physical and psychological caregiving by primary caregivers (7 items); and contextual resources that facilitate a sense of belonging (10 items) including spiritual, cultural and educational resources. Higher scores reflect a higher degree of resilience. The scale was translated to Arabic and back translated and reviewed by relevant experts for validity of the items and feedback was considered with minor changes. Internal consistency was validated using Chronbach's alpha ($\alpha = 0.93$).

Statistical analysis

SPSS Version 20.0 for Windows was used for assumption testing, transformations, and statistical analyses (Pearson correlations, t tests, and analyses of

variance). Frequency tables that showed sample characteristics were done. Moreover, independent T test was conducted to find differences between two groups. One way ANOVA using the Schaffer Test was conducted to compare means of more than two groups. For association between different variables, Pearson correlation test was conducted. Linear Logistic regression was conducted to find the prediction of dissociative symptoms and resilience by each traumatic event.

Result

The study consisted of 400 adolescents (179 boys which represented 44.8%) and 221 girls representing 55.2%) aged ranged from 15-18 years (M = 16.7, SD = 0.85. Regarding place of residence, 72 of adolescents lived in North of Gaza (18 %), 138 in Gaza city (34.5 %), 64 in middle area (16%), 77 in Khan Younis (19.2 %) and 49 in Rafah (12.2 %). Regarding number of siblings, 54 had three or fewer (13.5%), 167 had 4-6 siblings (41.8%) and 179 had seven or more (44.8%). Regarding monthly family income, 146 had less than $250 US (36.5%), 90 had from $250 to $500 US (22.5%), 75 had from $501 to $750 US (18.8%), and 89 had more than $751 US (22.3%). Eleven fathers were not educated (2.8%), 30 were educated to the elementary level (7.5%), 49 were educated to preparatory level (12.3%), 99 were educated to secondary level (24.8%), 77 educated to diploma level were (19.3%), 105 educated to university level (26.3%), and 29 finished post graduate education (7.3%). Regarding mothers' education, 10 mothers were not educated (2.5%), 19 educated to the elementary level (4%), 53 educated to preparatory level (13.3%), 158 educated to secondary level (39.5%), 73 educated to diploma level (18.3%), 75 educated to university (18.3%) level, and 15 finished post graduate education (3.8%). Sixty seven fathers were civil workers (16.8%),[37] 30 were skilled workers (9.3%), 105 were civil employers working and getting salary (26.3%), 44 were civil employers not working and getting salary (11%), 50 were merchants (12.5%), 5 were fishermen (1.3%), 2 were farmers (5%), 65 were unemployed (16.3%) , and 25 had other jobs (6.3%). Regarding mothers, 353 were house wives (88.3%), 12 were workers (3%), 32 were employer working and getting salary (8%), 1 was employer with salary, but did not at work (0.3%), 2 were merchants (0.5%).

Frequency and severity of trauma due to 8 days war on Gaza

The most common traumatic events were: hearing shelling of the area by artillery (96.3%), watching Palestinian mutilated bodies on TV (95.3%), witnessing the signs of shelling on the ground (95%), hearing the sonic sounds of the jetfighters (93.25%), and hearing the loud voice of pilotless plans (92%). The average experience demonstrated that every adolescent was subjected to nine traumatic events (SD= 2.46). Results showed that mean traumatic experiences of boys was 9.2 vs. 9.54 for girls. No statistically significant differences in traumatic experiences due to war on Gaza according to gender, family income, number of siblings, and parent's education and work.

Level of traumatic events

In order to find the level of traumatic events, we recoded trauma as mild (less than 4 events), moderate (5-10 events), and severe (more than 11 trauma). Out of the total sample, 8 reported mild (2%), 258 reported moderate (64.5%) and 134 reported severe traumatic experiences (33.5%).

Frequencies of dissociative experiences symptoms

The current sample experienced many dissociative symptoms. The highest was "when being in an unwanted place I can escape through my thoughts" (33.25 %), and I feel like, there are many people inside me (20.50 %). Whereas, the lowest item was "I forget doing my homework when teachers ask me to do" (2.75%), "I get involved in playing with my toys, like cars, animals and

dolls as if they were alive" (3.0 %). Dissociative symptoms ranged from 1 to 4.4 with mean 2.49 (*SD* = .61).

Sociodemographic variables and dissociative symptoms

In order to find the differences in dissociative symptoms according to sociodemographic variables, independent t test was conducted if the variables were two and less while One Way ANOVA was conducted for more than two variables.

The results showed that mean dissociative symptoms in girls was 75.67 (*SD* = 18.25) vs. 73.65 (*SD*= 18.49) in boys. No statistically significant differences in dissociative symptoms according to gender, age, place of residence, parent's jobs and education.

Table 1: Sociodemographic characteristics of the study population (N = 400)

	No.	**%**
Gender		
Male	179	44.8
Female	221	55.2
Mean age= 16.7 y, SD = 0.85		
Place of residence		
North of Gaza	72	18
Gaza	138	34.5
Middle area	64	16
Khan Younis	77	19.3
Rafah	49	12.3
Sibling number		
3 or fewer	54	13.5
4-6 siblings	167	41.8
7 or mores siblings	179	44.8
Family monthly income		
Less than $250 US	146	36.5
$251- $500 US	90	22.5
$501 - $750 US	75	18.8
More than $751 US	89	22.3
Father education		
Not educated	11	2.8
Elementary	30	7.5
Preparatory	49	12.3
Secondary	99	24.8
Diploma	77	19.3
University	105	26.3
Post graduate	29	7.3
Mother education		
Not educated	10	2.5
Elementary	16	4.0
Preparatory	53	13.3
Secondary	158	39.5
Diploma	73	18.3
University	75	18.8
Post graduate	15	3.8
Father work		
Unemployed	65	16.3
Simple worker	67	16.8
Skilled worker	37	9.3
Civil employer working and getting salary	105	26.3

Civil employer not working and getting salary	44	11.0
Merchant	50	12.5
Other	32	8.1
Mother work		
House wife	353	88.3
Simple worker	12	3.0
Civil employer working and getting salary	32	8.0
Civil employer not working and getting salary	1	0.3
Merchant	2	0.5

Frequency of resilience items

The most common resilience items were: "Completion of my education is important to me" and “I am proud of my citizenship” (96.25%), “Faith in God and being religious are the source of my strength” (95%).

Mean resilience was 112.18 (*SD*= 13.03), for individual resources, such as personal skills, social skills, and peer support, the mean was 44.06 (SD= 5.57), physical and psychological caregiving by primary caregivers mean was 27.42 (*SD* = 5.1), and contextual resources including spiritual, cultural and educational resources mean was 37.42 (*SD*= 4.76).

Table 2: Frequencies of traumatic experiences after the 8 days war on Gaza Strip

	Yes		**No**	
	No.	%	No.	%
Hearing shelling of the area by artillery	385	96.3	15	3.8
Watching mutilated bodies on TV	381	95.3	19	4.8
Witnessing firing by tanks and heavy artillery at own home	380	95.0	20	5.0
Hearing the loud voice of robot plans	374	93.5	26	6.5
Hearing the sonic sounds of the jetfighters	368	92.0	32	8.0
Hearing about the killing of a friend	264	66.0	136	34.0
Witnessing assassination of people by rockets	233	58.3	167	41.8
Receiving threatening letters by the Israeli army through local television or radio	183	45.8	217	54.3
Unable to leave your home with family members due to fears of shelling in the street	179	44.8	221	55.3
Forced to leave your home with family members due to shelling	173	43.3	227	56.8
Physical injury due to bombardment of your home	163	40.8	237	59.3
Receiving pamphlets from airplanes to leave your home at the border and to move to the city centers	157	39.3	243	60.8
Threatened by telephone to evacuate your home before bombardment	90	22.5	310	77.5
Hearing about the killing of a close relative	49	12.3	351	87.8
Witnessing injury of a brother or a sister due to shelling	44	11.0	356	89.0
Witnessing injury of father or mother due to shelling	43	10.8	357	89.3
Witnessing firing by tanks and heavy artillery at neighbors’ homes	43	10.8	357	89.3
Witnessing injury of a neighbor or a friend due to shelling	40	10.0	360	90.0

Sociodemographic variables and resilience

In order to find the differences in resilience factors according to sociodemographic variables, independent t test was conducted if the variables were two and less,

while One Way ANOVA was conducted if the variables were more than two.

The results showed no statistically significant differences in the total resilience and subscales according to the socio-demographic factors of gender, age, type of residence and parents work whereas resilience was higher in adolescents with fewer siblings.

Table 3: Resilience in children

	Number items	Mean	SD
Resilience	28	112.18	13.03
Individual resources	11	44.07	5.57
Physical and psychological caregiving	7	27.43	5.11
Contextual resources	10	37.24	4.76

Relationships between traumatic experiences, dissociative symptoms and resilience

Pearson correlation coefficients test was conducted to find relationships between traumatic events, dissociative symptoms and resilience. There was a statistically significant negative relationship between dissociative symptoms and total resilience (r= -0.26, p= 0.001), individual resources (r= -0.18, p= 0.001), physical and psychological caregiving (r= -0.27, p= 0.01), and contextual resources (r= -0.13, p= 0.001). There was a statistically significant positive relationship between traumatic events and total trauma and total resilience (r= 0.23, p= 0.001), individual resources (r= 0.14, p= 0.01) and contextual resources (r= 0.10, p= 0.01).

Table 4: Pearsons correlation factor between trauma, dissociative symptoms and resilience

	Total trauma	Total dissociative symptoms
1. Total trauma	1	
2. Total dissociative symptoms	.23 **	1
3. Resilience	.10 *	-.26 **
4. Individual resources	.14 *	-.18**
5. Physical and psychological caregiving	.01	-.27 **
6.Contextual resources	0.10*	-.13 **

*P<= 0.05, **P<=0.01

Prediction of dissociative symptoms by types of traumatic events

In a multivariate regression model, each traumatic event was entered as an independent variable, with total dissociative scores as the dependent variable. Six traumatic events were significantly predicted dissociative symptoms: witnessing firing by tanks and heavy artillery at neighbors' homes: (B=0.17, p=0.001); witnessing assassination of people by rockets: (B=0.13, p=0.01); hearing about the killing of a close relative (B=0.11, p=0.03); forced to leave you home with family members due to shelling (B= 0.10, p=0.04); watching mutilated bodies on TV: (B=0.10, p=0.006) and shot by bullets, rockets, or bombs, and unable to leave you home with family members due to fears of shelling in the street (B=0.10, p=0.04). (R2=0.10, SE= 17.52)

Prediction of resilience by types of traumatic events

In a multivariate regression with each traumatic event entered as an independent variable, and total resilience scores as the dependent variable, two traumatic events were significantly associated with total resilience: hearing shelling of the area by artillery (B=0.23, p=0.001); witnessing shooting of sister or brother (B= 0.14. p=0.01) (R2 = 0.05, SE 12.6).

Discussion

The study found that the highest traumatic event was hearing shelling of the area by artillery, watching mutilated bodies on TV, witnessing the signs of shelling on the ground; whereas; the least traumatic events were physical injury due to bombardment of your home and then witnessing shooting of a close relative. Our study showed mean traumatic experiences due to war on adolescents was nine events. This was higher than previous studies of war on 2008-2009[2, 3, 4]. Our study showed no significant differences according to adolescent gender which was inconsistent with most studies in the area which showed that boys were traumatized than girls[4, 21, 2, 3]. Also, in other studies boys were more traumatized than girls[25]. Such findings in the present study could be due to cultural factors in which boys move more freely outside the home and are more exposed to all manner of violence and trauma while girls are kept safe at home and not allowed to join boys in their activities outside the homes.

The present study showed that mean dissociation symptoms was 2.6. Results were consistent with previous research on adolescent psychoform dissociation from non-clinical populations, which had reported A-DES scores ranging from 1.27 and 2.66[26, 27, 28]. The present study showed no significant differences in dissociative symptoms according to gender. This finding was inconsistent with studies which reported that girls had higher level of peritraumatic dissociative symptoms more than boys[29,30]. Findings in the current study showed that there were statistically significant differences in dissociative symptoms in adolescents whose fathers had been educated to the primary level. There were differences in prevalence of dissociative symptoms according to family size in favor of adolescents with 8 or more siblings. Our findings were consistent with the study of 71 adolescents (12–18 years old) attending Australian community mental health and counseling services. The mean A-DES score was 3.37 (SD=2.12) and there were no differences in psychoform dissociative experiences by gender[32]. The study showed there were positive relationships between traumatic experiences and dissociative symptoms among adolescents[33]. This was consistent with studies that demonstrated a significant positive relationship between the existence of dissociative symptoms and traumatic events[13, 32]. While others demonstrated that childhood trauma has been associated with increased risk for both panic disorder and dissociative symptoms in adulthood[11]. In another study among adolescents' psychiatric patients, results showed an increase in the degree of dissociative symptoms in patients with a history of sexual abuse, physical abuse, neglect and stressful life events[12]. Researchers found that exposure to any type of maltreatment was associated with greater dissociation and posttraumatic symptomatology in preschool-age children with documented sexual abuse displayed high levels of posttraumatic symptoms, whereas children with documented physical abuse tended to use dissociation as a primary coping mechanism[34].

Mean resilience was 112.18, personal competence was 27.14, social competence was 16.92, structured style was 7.61, family cohesion was 19.82, and social resources mean was 40.69. The results showed no statistically significance differences in the total resilience and subscales according to the socio-demographic factors as gender, age, type of residence and parents work, whereas, resilience was higher in adolescents with fewer siblings.

This study showed there was a positive relationship between traumatic events and total resilience, personal and social competence. Such findings suggest that experiencing traumatic events can lead to more effort in adolescents to have more personal and social competence. There is enough evidence to assert that processes associated with resilience protect against the traumatic effects associated with acute and chronic stressors, but the mechanisms are complex and contextually and culturally dependent. There is evidence that aspects of positive psychological functioning like social bonding, a capacity for empathy, and a sense of

coherence can co-occur with trauma-related symptoms typically associated with posttraumatic stress disorder[35,36]. Similarly, others postulated that resilience occurs when there is significant exposure to adversity, such that protective processes interact with the stressors a child experiences. In these contexts of stress, resilience is the capacity of children to navigate to the psychological, social, cultural, and physical resources that help them nurture and sustain well-being, and their capacity on their own and with others to negotiate for what they need to be provided in culturally meaningful ways[37]. Our findings were consistent with our previous study after the 2008-2009 war which showed that resilience was positively increased by exposure to traumatic events due to war[38].

Clinical implications

The present study showed that Palestinian adolescents had been victims of continuous trauma which increased risk of psychopathology such as dissociative symptoms. Such symptoms had a negative impact on adolescent resilience when faced with adversity. Such reactions require psychosocial interventions based on a public health and developmental process, which usually include engaging children in community-based recreational and cultural activities in the war-affected populations. Art and games that form part of these interventions have been found useful for healing psychological wounds. Therapeutic activities, such as role-play and drama, puppet shows, and so forth, increase children's sense of control and self-protection and can be utilized to teach the skills that may protect them against abuse. It is imperative that the role of parents is enhanced through parental education and awareness-raising regarding the impact of displacement on family, and especially children's development. Specific parental skills can be developed to increase the child's sense of security and decreased sense of vulnerability and uncertainty.

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ملخص

الهدف: هدفت هذه الدراسة إلى معرفة تأثير الخبرات النفسية الصادمة الناتجة عن حرب الايام الثمانية على الأعراض الانشقاقية وعلاقتها بالصمود النفسي لدي المراهقين الفلسطينيين في قطاع غزة. **الطريقة:** تم اختيار عينة عشوائية من 400 طالب وطالبة من 10 مدارس منتشرة في خمس مناطق من قطاع غزة. حيث بلغ عدد الاولاد 179 ولداً و عدد البنات 221 بنتاً. أجريت معهم مقابلات و باستخدام استيانات تحتوى على الحالة الاقتصادية و الديموغرافية ، ومقياس الخبرات الصادمة الناتجة عن حرب الايام الثمانية على قطاع غزة سنة 2012، مقياس الاعراض الانشقاقية، ومقياس الصمود النفسي. **النتيجة:** أظهرت الد راسة أن متوسط الخبرات الصادمة التي تعر ض لها كل مراهق 9 خبرات صادمة. و لا توجد فروق ذات دلالة إحصائية في عدد الخبرات الصادمة بسبب الحرب على غزة حسب الجنس و كذلك لم تكن هناك فروق حسب عدد الأخوة، ودخل الأسرة، و تعليم و عمل الوالدين. أظهرت النتائج من متوسط الاعراض الانشقاقية لدى الفتيات كان 75.67 مقابل 73.65 في الأولاد. لاتوجد فروق ذات دلالة إحصائية في الاعراض الانشقاقية وباقي العوامل الديموغرافية مثل الجنس، والعمر، ومكان الإقامة، وعدد الأخوة، ودخل الأسرة، و تعليم وعمل الوالدين .

كان متوسط الصمود النفسي في المراهقين 112.18، ومتوسط الموارد الفردية 44.06، ومتوسط العناية الجسدية، و النفسية من الأهل كان 27.42، ومتوسط المصادر المجتمعية (الدينية، والثقافية، و التعليمية) كان 37.42. لا توجد فروق ذات دلالة إحصائية في الصمود النفسي و باقي العوامل الديموغرافية مثل عدد الأخوة، ودخل الأسرة، وتعليم و عمل الوالدين. بينما كان هناك صمود نفسي أكثر لدي المراهقين الذين لديهم أخوة أقل من 4 اخوة. أظهرت النتائج أن هناك علاقة سلبية ذات دلالة إحصائية بين الاعراض الانشقاقية والصمود النفسي، والموارد الفردية، والعناية الجسدية و النفسية من الأهل ، والمصادر المجتمعية (الدينية، والثقافية، و التعليمية). بينما كانت هناك علاقة إيجابية ذات دلالة إحصائية بين الخبرات الصادمة الناتجة عن حرب الايام الثمانية على قطاع غزة والصمود النفسي الكلي، والموارد الفردية، والمصادر المجتمعية. **التطبيقات العملية:** أظهرت هذه الدراسة أن المراهقين الفلسطينيين كانوا ضحايا الصدمات النفسية المستمرة التي زادت مخاطر التعرض للأصابة بالأمراض النفسية مثل الاعراض الانشقاقية . كان لمثل هذه الأعراض التأثير السلبي على الصمود النفسي لدى المراهقين في مواجهة المحن اليومية. مثل هذه الأعراض تحتاج للتدخلات النفسية والاجتماعية على أسس تنموية وصحية، وعادة ما تشمل إشراك الأطفال في الأنشطة المجتمعية الترفيهية والثقافية مثل الفن والألعاب، ووجد بأنها مفيدة للشفا من تأثيرات الصدمات النفسية.

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